THE NEW PRIMARY-CARE PHYSICIAN*

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AS IS TRUE of most titles, this one is only partially accurate. There really is nothing new in present or projected models of primary-care physicians—just rearrangements of present roles and a redistribution of responsibilities. Training and practice will be dictated by the organizational mode chosen for the delivery of primary care. Many factors influence the tasks, responsibilities, and behavior of the primary-care physician. These factors will influence the arrangements which will emerge and those arrangements, in turn, will influence the kind of primary-care physician who will develop. I shall start by discussing some of the factors which seem most likely to push the practice of primary care and, therefore, training for providing this care in certain directions. Much of what I shall say is well known. Its acceptance, however, varies markedly and it is worth repeating, if only to stimulate debate and discussion.

Care-seeking behavior by patients varies less by virtue of the distribution of illness in the society than it does by virtue of the characteristics of the particular population. We are all aware of the vast differences in care-seeking behavior in different populations. How people react to symptoms is related to their socialization, life experience, learning, and the values of the cultural group to which they are exposed. As Mechanic[1] has pointed out, visiting a doctor is only one of many possible responses for a person suffering psychological or physical pain, distress, or disruption in life activities. Using Kerr White's[2] conservative estimates of the occurrence of physical symptoms in the population—based on an action criterion such as going to bed or taking medication—it is apparent that a large portion of the population (approximately three quarters) has symptoms in any given month comparable to those that physicians see. Approximately

*Presented as part of a *Symposium on the Medical School and Its Surrounding Community* held by the Committee on Medical Education of the New York Academy of Medicine October 14, 1976.

one in three of these patients will seek a physician. These estimates are based on acute and chronic physical illness and do not include the large amount of psychiatric morbidity in the population. The rates for psychiatric symptoms in a population vary widely, depending on the study method. Mechanic[3] assumes that a 10% rate would be conservative; some studies have reported rates as high as 60%. This is of great importance, because the view that people have of health or illness differs markedly from that held by most physicians. As was pointed out by Zola and Stockel many years ago,[4] patients seek help for a variety of reasons, and those reasons may not be related to the symptoms which are the stated reasons for seeking help. The patient's perception of his or her capacity to function is the important determinant, not the severity of the symptom presented. The disruption of activities is the most important determinant of severity in the patient's view.

Many patients seen in primary-care settings present physical symptoms as a sort of ticket which legitimizes relief from the responsibility of the patient's role in time of psychosocial stress; the uninterested or psychologically uneducated physician either may view these complaints as trivial or may overutilize laboratory and x-ray tests in an attempt to make the patients' complaints coincide with his professional view of illness.[5] Last year $15 billion were spent on laboratory tests. The rate of increase in the use of laboratory tests is about 10% per year. This does not seem to be related to the number of patients or to the appearance of unusual illness. It seems more related to the physician's training and practice. In a study conducted in four major teaching hospitals in New York City, walk-in patients were found to have an average of 2.4 return visits to the clinic; an examination of the charts of a statistical sample of these patients revealed that 30% of the first return visits were not medically indicated. Many were for the results of laboratory tests which should not have been ordered on the first visit.[6] This is not an unusual finding for primary care delivered in hospital outpatient departments; the young house officers who usually provide such care have views of illness which are influenced greatly by their major function in the hospital: care of a horizontal patient who usually is physically ill and has been through a rather intensive screening process.

A very different picture is obtained in the usual primary-care setting. Balint[7] maintains that the difficulties of life and psychological distress frequently trigger the use of physicians' services. The high rate of psycho-

logical distress among ambulatory patients may reflect the contribution such distress makes to physical symptoms and illness, may itself be the impetus to seeking help, or both. Mechanic[8] and others[9] have excellent discussions of the major part which psychosocial factors play in the use of primary-care physicians and of the role of these physicians in dealing with these problems. Either the primary-care physician or the organization of primary care in some way must provide for effective diagnosis and treatment of psychosocial components which present as primary or secondary factors for care to be effective.

Another major factor that influences the delivery of primary care is the accessibility of care. Geographical proximity and location are major considerations in the utilization of primary-care services. A useful study by Novick et al.[10] of the use of well-baby stations by mothers in New York City when their children had acute illness clearly demonstrated that the use of these facilities was directly related to the proximity of the patient to the facility. The only facility which had a relatively high rate of utilization by its registered target population was located in the large Polo Grounds housing development.

Despite the difficulties which have plagued neighborhood health centers for other reasons, these centers have successfully delivered primary health care. In Boston the network of such centers is an integral part of the primary health-delivery system and has offered successful competition to so-called Medicaid mills. In New York several informal surveys of those who utilize so-called Medicaid mills have commented favorably on the geographic proximity and the comfortable atmosphere, which the patients find more intimate and less intimidating than that of hospital clinics. In New York such facilities flourish within a few blocks of almost all major medical centers and their complex outpatient departments.

Most hospitals are unable to match patients to visits to give a picture of who is using the outpatient clinic. In one major medical center where we were able to do so, we found that while 127,000 patients accounted for approximately 480,000 visits in one year, 20% of the patients accounted for 60% of the visits. Obviously, the amount of primary care being given was minimal, since most of the patients were seen only once or twice a year and most of the return visits were to specialty clinics.

It would seem difficult, if not impossible, to train physicians to give primary care, which is by definition horizontal in time, in a delivery system which has a vertical structure.

Several other factors have influenced and continue to influence the delivery of primary care, especially to urban populations. One of these stems from the fact that physicians tend to get rewarded in many ways. Economic motivation, while important, is by no means the only or even the most important means of payment. Physicians also tend to enjoy identification with some of their patients and the sharing of a personal relation. This, obviously, is easier to accomplish when patient and physician share social values and common experiences. It is difficult for the middle-class physician to do this if his entire practice is drawn from a different sociocultural background. The most idealistic physician is soon worn down if he works five days a week in the inner city with multiproblem patients; he has little to share with these patients on other than a professional level. Organizational arrangements of primary care which ignore this consideration are not likely to succeed, nor can one get around this through efforts to recruit and train students from deprived sociocultural backgrounds; when they finish their training they are no less middle class than their classmates and are not anxious to return to the inner city to spend their professional lives.

In our complex urban medical centers we turn out physicians whose value system is centered on the excellent scientific training they receive. The hub of their training is and has been the hospital, where the emphasis is on the critically ill patient. Internship further reinforces this emphasis. We have increased the number of physicians in practice, and in 1976 had more than 57,000 students in medical schools. It is too late to change the training of those who are in postgraduate training, and it probably is too late to expect a major change in the training of those in school. What is needed is the training of medical students who see a group of ambulatory patients in an ongoing relation over time.

We have a one-tiered system. Most physicians expect and have hospital privileges and it is highly unlikely that that will be changed. So our primary-care physicians will expect to be part of a system which enables them to follow their patients who become hospitalized. We have created, fostered, and encouraged this situation, and any organizational structure which ignores it either will be second class or will fail.

As one examines the meagre studies of satisfactions or complaints of physicians, it becomes apparent that there is a considerable push toward group practice. The number of solo practitioners in urban primary care continues to decline and those who remain complain of being overworked

and overburdened. This is true no matter what the method of reimbursement. Physicians in England studied by Mechanic[11] complained about the trivial nature of their patients' complaints in direct proportion to the size of their panel, and primary-care physicians in the United States in solo, fee-for-service practice complained about being overburdened and overworked.

As a final factor to discuss, but by no means the final determinant of what primary care should be, is the issue of specialization and its relation to primary care. We have more than 6,000 cardiologists in the United States, most of whom spend less than half their working time doing cardiology. Dermatologists spend much of their time delivering care which, once prescribed, is routine and could be handled by any competent physician. Indeed, the national ambulatory-care survey shows that most internists in primary care treat dermatologic conditions and refer only those which are unusual or resistant to treatment. It is difficult to understand how we can develop a system of primary care if the specialists retain most of the patients referred to them for consultation. It is difficult to believe that a well-trained internist cannot manage most of the cardiac, diabetic, arthritic, and other patients with chronic illness who occasionally are referred for consultation, but should be returned for management to the primary-care physician.

An additional factor which complicates a primary-care physician's function in an urban setting is the complexity of management. In a study just released by the Columbia Center for Community Health Systems, Piore and her co-workers[12] reported on the flow of funds for health care in New York City in 1975. One finding of major importance bearing on the delivery of primary care was that more than 50% of the receipts of voluntary hospitals and more than 40% of the income of private practitioners in that year were public funds. The management and processing of claims and forms are complicated operations which require management skills and tight business controls. These are neither taught nor valued in the training and development of physicians, yet it is difficult to see how primary care can be delivered in the complex urban setting without attention to these details.

I have focused on primary care in urban settings because 70% of our population lives in metropolitan areas. The problems and solutions in rural areas are no less complicated and also must be addressed. There are, however, some major examples of successful experiments in solving these

problems, such as the work of the University of North Carolina Area Health Education Program.[13]

Having noted some of the factors which impinge on the primary-care physician, I shall comment on them and offer a possible model for their inclusion in an ideal urban primary-care system.

As stated earlier, it is impossible to deliver good care in a vertically structured system such as our current hospital outpatient departments with their specialty clinics. It is impossible to offer good training in the context of bad service. All the forces at work in our present hospital ambulatory-care systems foster poor service. Patients must be seen as a whole or we can never make the proper connections between their complaints and their psychosocial conditions. Continuity is less a demand of patients (although a real need) than the need for the proper organization in good health care. We must relate both to the way the particular patient presents and to the meaning of the complaints to the individual. We have, instead, tried to make patients conform to a highly structured delivery system which is fine for the hospital but not for the provision of ambulatory care. The delivery of inpatient services and outpatient services are different and require different organizational structures.

We must use the excellent scientific backgrounds of internists and pediatricians in an appropriate manner. We have inveighed for years about the need for physicians in primary care to be aware of psychosocial problems, yet we still select students on the basis of scientific achievement and aptitude. The value system is skewed in one direction, while the actual practice of primary care demands something quite different. We have tried to reconcile these divergent philosophies and skills and have tried to insist that the physician should be all things to all people. We have suggested that different training or different selection would solve this dilemma. We have not achieved our goal. If we are to use the increased number of physicians we have produced, we must find a way of achieving the goal—not by changing the physician but by adapting the system to the physicians we have produced in what many believe are inadequate numbers.

After this lengthy preamble, I shall make a presumptuous leap and offer a model which may be able to meld the diverse forces into a system of good primary care.

The hospital will and must remain the hub of the health-care delivery system, but ambulatory care must move off-site into the community. Separate but interconnected corporations should be developed around de-

fined populations to manage the off-site systems. The hospital ambulatory-care system should assume responsibility for these corporations.

To retain a mix of patients from various socioeconomic groups—which gives both fiscal stability and the opportunity for the physician to care for diverse patients—hospitals must imitate large department stores. Ambulatory services should be developed in middle-class and upper-middle class neighborhoods as well. The distribution of satellites should mirror the distribution of population. Business management should be in the hands of managers.

Physicians should be organized into groups large enough to serve several satellite centers. The physicians should rotate, spending portions of their week in different centers so as to provide the physicians with a mix of patients while still preserving continuity of care. The tie to the hospital would insure continuing education, access to superspecialists, and admitting privileges for their patients. Also, for the physicians status accrues by identification with institutions, among other ways. The many advantages to the physicians also include control over their standards of practice, the opportunity for a reasonably scheduled workweek, and the inclusion of guaranteed incomes and fringe benefits. The hospital assures itself of a reasonable share of the market from which its patients come.

The group practices should be organized to insure adequate handling of the psychosocial aspects of the problems and complaints of many patients. To accomplish this I suggest that we meld the superb, scientifically trained internists and pediatricians with a group of specially trained social workers and nurse-practitioners (although social workers seem to have more interest and aptitude in the psychosocial areas than nurse-practitioners). These professionals should receive specific training for diagnosis and management under supervision, including the monitoring of patients on medications. Psychiatrists should be used as consultants and supervisors rather than as therapists, except for an occasional case. This system envisions the incorporation of the major portion of psychiatric care into the primary-care system. We shall never be able to give adequate psychiatric care to the population unless the provision of such care is incorporated into the mainstream of the health-care delivery system.

I have described the utilization of internists and pediatricians into a new organizational structure for the delivery of primary care. Many problems are posed by this model, for example those connected with the hospitals

taking on an expanded role by moving into the community, the financing and management of a separate system, the rapid training and retraining of social workers or nurses or both for the role described, and the reorientation of the hospital services to give status and position to the physicians delivering primary care. These problems, however, are much less difficult than those of training a new breed of primary-care physicians and this system makes use of our already expanded physician-manpower pool.

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